301 837 INSTITUTIONAL

301.1 GENERAL INFORMATION

Introduction

This chapter contains information on processing electronic claims based on the 004010X096 version of the ASC X12N Institutional Health Care Claim Implementation Guide (837I) and the Addenda (004010X096A1) dated October 2002. This document will identify information that is specific to conducting Electronic Data Interchange (EDI) with the Illinois Medical Assistance Program and other health care programs funded or administered by the Illinois Department of Healthcare and Family Services (HFS).

Questions, comments, or suggestions regarding this information should be directed to hfswebmaster@illinois.gov

Billing Information

The institutional 837 (837I) should be used to submit electronic claims to HFS for any service that is currently submitted on the UB92, such as the following:

Inpatient hospital services, both Medicaid and Medicare crossovers
Outpatient APL hospital services
Outpatient Medicare Crossovers
ASTC APL services
Hospice services
Renal dialysis services, including State Renal, Medicaid and Medicare crossovers

The 837I must also be used to submit electronic claims to HFS for:

Home Health services

The professional 837 (837P) must be used to submit electronic claims to HFS for any service that is not currently submitted on the UB92, except for Home Health services (see above).

NOTE: **Home Health** services that are submitted on **paper** must continue to be submitted using the DPA 2212 (not the UB-92).

Providers must continue to follow the policies outlined in UB-92 for Illinois Billing Procedures, HFS's provider handbooks, notices, rules and laws.

Amount Fields - The maximum number of characters to be submitted in the dollar amount field is nine (9) characters. Dollar amounts in excess of 9,999,999.99 (excluding commas and the decimal point) may be rejected.

Attachments – Providers who submit electronic claims that require an attachment must continue to separately mail the paper attachment to the Department. NOTE: No other submission method (fax, e-mail, electronic) will be accepted at this time.

All attachments must be accompanied by the Electronic Claim Attachment Form cover sheet. Providers must report the "Attachment Control Number" in PWK06 of the 2300 Loop. The PWK identifier should be unique for each claim. Providers must use the same PWK identifier for all attachments that apply to the claim. Providers will not be allowed to use the PWK identifier more than once, even for re-submittals or rebills.

In order to re-associate the attachments with the electronic claim, providers must submit all attachments for a claim accompanied by one cover sheet.

Code guidelines - HFS will process the following number of codes and will not consider additional codes for adjudication and payment determination of the claims at this time. However, additional codes in each group up to the maximum specified in the Implementation Guide will not cause the claim to reject.

Occurrence Span	7
Occurrence Codes	10
Condition Codes	10
Value Codes	12
Principal Procedure	1
Other Procedures	5
Principal Diagnosis	1
Admitting Diagnosis	1
“E” Diagnosis	1
Other Diagnoses	8
Modifiers	0
NDCs	0

Coordination of Benefits – See Section 301.4 for more information.

DCFS Screening Visit – To identify a hospital service as a “DCFS Screening”, the provider must use Source of Admission “8” (CL102, Loop 2300) for billing of DCFS initial visits.

HCPCS Procedure Codes have a maximum size of five (5) characters.

Home Health – If the home health services follow the Subscriber’s discharge from a hospital, the facility must report the hospital discharge date in the Occurrence

Information (HI) of Loop 2300, using Occurrence Code "22". If the date is not reported, follow the prior approval requirements described in the Home Health Handbook.

If more than one skilled nursing visit per day is needed within 60 days of hospital discharge, providers must submit a prior approval request for the total number of visits required for the approval period. Prior approval is required regardless of whether the claim is billed electronically or on paper. If billing electronically, the provider must omit the discharge date from the Occurrence Information (HI) of Loop ID 2300 and indicate the number of visits in Loop ID 2400 SV205.

ICD 9 CM Diagnosis codes have a maximum size of five (5) characters, excluding the decimal point.

ICD-9 Procedure codes have a maximum size of four (4) characters, excluding the decimal point.

Modifiers - HFS will not consider modifiers in adjudication and payment determination of 837 Institutional claims, with the exception of claims submitted for services rendered by Home Health Agencies or Nursing Agencies.

National Drug Code (NDC) - HFS will not consider NDCs in adjudication and payment determination of the claims at this time.

Outpatient Medicare/Medicaid Crossover Claims – Report the total number of "Departments Visited" by the patient during the billing period using Value Code "24". See Section H-251.6 of the Hospital Handbook for additional information.

Patient – For HFS, the **Subscriber** is always the Patient. Claim information should be placed at the subscriber hierarchical level (even when using the mother's Recipient Identification Number to bill for newborn services). Claims with information in the Patient hierarchical level will not be accepted into our processing system.

Revenue Code guidelines - HFS will consolidate revenue codes so that total for each claim does not exceed 54 codes. HFS strongly recommends that providers roll-up the revenue codes to create a claim with 54 or less lines.

Spenddown – The spenddown amount is to be reported with Value Code 66.

Subscriber – For HFS the Subscriber is always the Patient. Claim information should be placed at the subscriber hierarchical level (even when using the mother's Recipient Identification Number to bill for newborn services).

Taxonomy - For HFS, the provider taxonomy code will be utilized to derive the Department's unique categories of service. The HIPAA Provider Taxonomy code is

a ten-character code and associated description specified for identifying each unique specialty for which a provider is qualified to provide health care services. The providers must report in PRV01 of the 2000A Loop, code BI – "Billing Provider", which is equivalent to the Department's current "Provider" or PT – Pay-to, which is equivalent to our current "Payee." PRV02 must contain "ZZ", which is used to indicate the Provider Taxonomy Code. PRV03 must contain the Provider Taxonomy code, only if PRV01 contains "BI."

Total Charges – Utilize Loop 2300 CLM02 to report the Total Charges amount that was previously reported in Revenue Code "001". This amount must equal the total of all of the SV203 elements.

Void or Replacement of a Claim – The Department will accept an 837 transaction to void or replace a payable or pending payable claim, in place of HFS's proprietary paper adjustment. See Section 301.3 for more details.

301.2 TECHNICAL INFORMATION

This section contains information relating to transmitting information to the Department. This section will identify, down to the data element level, anything unique to the Department in regards to the EDI transaction.

Transmission Information

The Department will continue to support its Recipient Eligibility Verification (REV) system. The REV system allows authorized Vendors a means to submit and receive electronic transactions, on behalf of Providers, for processing. The Department will also support a Medicaid Electronic Data Interchange (MEDI) system whereby authorized Providers and their agents can submit and receive electronic transactions via the Internet.

EDI Information:

The Department has identified, down to the data element level, anything unique to our processing requirements in regards to the various EDI transactions. This document will identify only those things that the Department requires that are not clearly identified in the Implementation Guide.

IG Page #	Loop	Description	Element ID	Element Name	Remarks
61	1000A	Submitter Name	NM109	Identification Code	Must be your Federal Tax Identification Number.
67	1000B	Receiver Name	NM103	Organization Name	Must be "ILLINOIS MEDICAID".
			NM109	Identification Code	Must be "37-1320188".
71	2000A	Billing/Pay to Provider Specialty Information	PRV01	Provider Code	Must be "BI" for one occurrence of this loop.
			PRV02	Reference Identification Qualifier	Must be "ZZ" to indicate Taxonomy.
			PRV03	Reference Identification	Although the Taxonomy code is a situational data element, claim submissions to HFS meet the situation in the IG that states: "Required when adjudication is know to be impacted by the provider taxonomy code…." Therefore, Taxonomy is required by HFS on all claims. The provider must submit the appropriate taxonomy for the service billed. The range of taxonomy codes used by the Department to derive the Category of Service for each type of service is attached or will be submitted later. The complete list of taxonomy codes can found at www.wpc-edi.com.
76	2010AA	Billing Provider Name	NM103	Name Last or Organization Name	Must be the Provider's name exactly as it is shown on HFS's Provider Information Sheet.
82	2010AA	Billing Provider Secondary Identification	REF01	Reference Identification Qualifier	Must be "1D".
			REF02	Reference Identification	Must be the twelve-digit HFS Provider number as shown on the Provider Information Sheet.
91	2010AB	Pay-To Provider Name	NM108	Identification Code Qualifier	Must be "24". Providers must enter their 9 digit Federal Tax Identification Number for their designated payee.

IG Page #	Loop	Description	Element ID	Element Name	Remarks
97	2010AB	Pay-To Provider Secondary Identification	REF01	Reference Identification Qualifier	Must be "1D" if a value is present in REF02.
			REF02	Reference Identification	If the Provider has more than one Payee, Provider must enter the 1-digit Payee number from the Provider Information Sheet to identify which Payee will receive payment for these services. If REF02 is used, then REF01 must be set to "1D".
108	2010BA	Subscriber Name	NM103	Name Last or Organization Name	Must be the Last Name of the Recipient and exactly as it appears on the MediPlan Card, KidCare Card or SeniorCare Card.
			NM104	Name First	Must be the First Name of the Recipient and exactly as it appears on the MediPlan Card, KidCare Card or SeniorCare Card.
			NM105	Name Middle	Must be the Middle Name of the Recipient and exactly as it appears on the MediPlan Card, KidCare Card or SeniorCare card.
			NM107	Name Suffix	Must be the Name Suffix of the Recipient and exactly as it appears on the MediPlan Card, KidCare Card or SeniorCare Card.
			NM109	Identification Code	Must be the Recipient's 9-digit number as it is shown on the MediPlan Card, KidCare Card or SeniorCare Card.
126	2010BC	Payer Name	NM103	Name Last or Organization Name	Must be "ILLINOIS MEDICAID".
			NM109	Identification Code	Must be "37-1320188".
157	2300	Claim Information	CLM01	Claim Submitter's Identifier	HFS will process and return up to 20 characters only.
			CLM02	Monetary Amount	The amount reported here must equal the total of all of the SV203 elements. This amount was previously reported in revenue code 001.
			CLM05-1	Facility Code Value	For Home Health claims, the first position of the "Bill Type" must be a "3".
			CLM05-3	Claim Frequency Type Code	The only valid codes are 1-5, 7 and 8. See the "UB92 for Illinois Billing Procedures" for more details.
165	2300	Discharge Hour	DTP03	Date Time Period	HFS will only process the hours portion of this element. Minutes may be zero filled, if not available.

IG Page #	Loop	Description	Element ID	Element Name	Remarks
169	2300	Admission Date/Hour	DTP03	Date Time Period	HFS will only process the date and the hours portion of this element. Minutes may be zero filled, if not available.
171	2300	Institutional Claim Code	CL101	Admission Type Code	Must use for "Inpatient" claims.
			CL102	Admission Source Code	Must use for "Inpatient" claims,and use Source of Admission '8' for billing of DCFS initial visits.
			CL103	Patient Status Code	Must use for "Inpatient" claims.
173	2300	Claim Supplemental Information	PWK02	Report Transmission Code	Must be "BM", because HFS will only accept attachments by mail.
			PWK05	Identification Code Qualifier	Must be "AC," Attachment Control Number
			PWK06	Identification Number	Must contain the Attachment Control Number if the claim requires an attachment and the attachment has been sent separately.
182	2300	Patient Paid Amount	AMT02	Monetary Amount	If the Subscriber owes a spenddown, do NOT use this element. You must use Value code 66 to report the amount. DPA Form 2432 "Split Billing Transmittal Form" must also be submitted. DO NOT report the "patient credit" amount on the 837 as the Department is already automatically deducting it.
191	2300	Original Reference Number (ICN/DCN)	REF02	Reference Identification	When billing for Claim Type 7 or 8, you must use this element to report the Document Control Number (DCN) of the original paid claim that is to be voided or voided and rebilled.
200	2300	Medical Record Number	REF02	Reference Identification	HFS strongly recommends that you provide this data element on all claims. This information is returned to you to help locate files when records have been selected for peer review or audit.
242	2300	Principal Procedure Information	HI01-1	Code List Qualifier Code	For "Inpatient" claims, must use "BR". "Outpatient" claims, leave blank.
			HI01-2	Principal Procedure Code	For "Inpatient" claims, must use ICD-9-CM codes; for "Outpatient" claims, must use HCPCS codes in SV201 of the 2400 Loop.

IG Page #	Loop	Description	Element ID	Element Name	Remarks
267	2300	Occurrence Information	HI01-2	Occurrence Code	If the home health services follow the Subscriber's discharge from a hospital, the facility must report the hospital discharge date in the Occurrence Information (HI) of Loop 2300, using Occurrence Code "22". If the date is not reported, follow the prior approval requirements described in the Home Health Handbook. Other providers will report Occurrence Code(s) as appropriate/applicable.
280	2300	Value Information	HI01-2	Value Code	For hospital outpatient Medicare/Medicaid crossover claims, utilize Value Code "24" to report the total number of departments visited by the patient during the billing period. Report all other Value Code(s) as appropriate/applicable.
306	2300	Claim Quantity	QTY01	Quantity Qualifier	For HFS "outpatient" series claims, the number of series days for which outpatient services were provided must be reported in Loop 2300 - Claim Quantity.
321	2310A	Attending Physician Name	NM108	Identification Code Qualifier	The only value that will be used is "34" or "24".
326	2310A	Attending Physician Secondary Identification	REF01	Reference Identification Qualifier	If enrolled Provider must use "1D" to supply the attending physician's HFS provider number. If not an enrolled Provider, must use "0B" to supply the attending physician's State License Number OR use "1G" to supply the attending physician's UPIN OR use "SY" to supply the attending physician's Social Security Number.
328	2310B	Operating Physician Name	NM108	Identification Code Qualifier	The only value that will be used is "34" or "24".
333	2310B	Operating Physician Secondary Identification	REF01	Reference Identification Qualifier	If enrolled Provider must use "1D" to supply the operating physician's HFS provider number. If not an enrolled Provider, must use "0B" to supply the operating physician's State License Number OR use "1G" to supply the operating physician's UPIN OR use "SY" to supply the operating physician's Social Security Number.

IG Page #	Loop	Description	Element ID	Element Name	Remarks
335	2310C	Other Physician Name	NM108	Identification Code Qualifier	The only value that will be used is "34" or “24”.
340	2310C	Other Physician Secondary Identification	REF01	Reference Identification Qualifier	If enrolled Provider must use "1D" to supply the other physician’s HFS provider number. If not an enrolled Provider, must use "0B" to supply the other physician’s State License Number OR use "1G" to supply the other physician’s UPIN OR use "SY" to supply the other physician’s Social Security Number.
371	2320	Payer Prior Payment	AMT02	Monetary Amount	Use this to report the amount paid by another payer, which is **NOT Medicare**.
376	2320	Coordination of Benefits (COB) Total Medicare Paid Amount	AMT02	Monetary Amount	Use this to report the amount paid by **Medicare**.
416	2330B	Other Payer Secondary Identification and Reference Number	REF01	Reference Identification Qualifier	Must be "2U".
			REF02	Reference Identification	Must be the 3-digit TPL code followed by the 2-digit Status Code assigned by HFS to other payers. For example: REF*2U*90901~ Code 909= Medicare Part A Code 910=Medicare Part B For other TPL codes, please reference Appendix 9 in Chapter 100. For Status Codes, see Appendix 17 in Chapter 200, Handbook for Hospitals.
445	2400	Institutional Service Line	SV202-2	Product/Service ID	For "Outpatient" claims, use HCPCS procedure codes with the appropriate revenue code (SV201). For additional information see “APL Outpatient” under Billing Instructions.
456	2400	Service Line Date	DTP03	Date Time Period	HFS only uses the "from" date, if a date range (RD8 in DTP02) is specified.

301.3 VOID OR REPLACEMENT CLAIMS

The Department will now accept Claim Frequency Type Code (Bill Type) "7" (Replacement of a prior claim) and Claim Frequency Type Code (Bill Type) "8" (Void/Cancel of Prior Claim). This allows providers to void or replace an entire claim.

The following data elements must match the original claim:

Document Control Number (DCN)	Loop 2300, REF02
Provider Number	Loop 2010AA, REF02
Recipient ID Number	Loop 2010BA, NM109

If these elements match, the claim will be voided and the payment credited against a future voucher. If all three do not match, the transaction will be rejected.

If the elements for the new claim do not match the ones on the original claim, you must void the original claim with a Bill Type "8" and submit a separate replacement claim with the corrected information and the appropriate bill type (not 7 or 8).

301.4 COORDINATION OF BENEFITS (COB) INFORMATION

301.41 INSURANCE IN ADDITION TO ILLINOIS MEDICAID

For those claims where the subscriber has insurance in addition to Illinois Medicaid, utilize Loop 2330B, REF02 to report the 3-digit HFS TPL code, followed by the 2-digit status code. The complete list of TPL codes can be found in Chapter 100, Appendix 9 of the General Policy and Procedures Provider Handbook. The list of Status Codes can be found in Chapter 200 of Illinois' Handbook for Hospitals, Appendix 17.

301.42 MEDICARE CROSSOVER CLAIMS

Until the National Provider ID (NPI) is implemented, utilize Loop 2330B, REF02 to report the HFS TPL code for those claims where the subscriber has Medicare coverage, followed by the 2-digit status code.

	Code
Medicare Part A	909
Medicare Part B	910

The 909 or 910 Code, when utilized with the applicable status code, will assist HFS by clarifying the Medicare action.

301.43 COB - REPORTING PRIOR PAYMENT

Loop 2320 within the 837I can be used for reporting amounts paid by another payer including Medicare. Loop 2330B within the 837I can be used for Other Payer Secondary Identification.

301.44 COORDINATION OF BENEFITS

The Department does not accept COB claims from any other payer, **including** Medicare. Providers should submit claims to the Department in compliance with our current billing policies.